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ABSTRACT

The interrelatedness of the fields of nursing and sociology is discussed in this paper in an effort to encourage a sympathetic symbiosis between these two fields and between technical and general education. First, an overview is provided of recent trends in sociology, citing the influences of anthropologists and cultural historians on current views of U.S. society. Next, changes in the delivery of health services are examined, with focus on the implications of these changes for health services education. The need for health services personnel to understand and get along with people is underscored, and several key factors in this understanding are explored, including the importance of a patient's motivation, background, behavior, and involvement in the effective delivery of health services; organizational characteristics of hospitals, such as limited resources, a racial and cultural caste system, work pressures, and management policies; and interpersonal relationships with colleagues, patients, and patients' families. The paper then suggests that learning experiences on such sociological topics be developed and integrated into existing technical courses. After suggesting steps for the development of such modules, a series of concepts are discussed around which learning experiences could be developed. These include power and authority, values and the process of socialization, ethnicity, religion, the aged, language, and wellness. Eight learning activities related to these topics are appended. (AYC)

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USING SOCIOLOGY
THE APPLICATION OF CONCEPTS

A PAPER
FOR THE
PENNSYLVANIA SOCIOLOGICAL SOCIETY
5 NOVEMBER 1983

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JC 830 559

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Both the fields of nursing and sociology are dynamic processes and have in common a person-oriented raison d'etre. They are both currently analyzing their practices, establishing new goals, involving themselves in new research and experimenting with new approaches relative to their fields.

As authors of the following work, we are proud to be involved in exploring aspects of contributing to our respective and each other's field. We begin with an overview of the history of our professions and their interrelatedness. We then use examples of actual issues, in terms of both structure and process, to offer suggestions for education of nursing students to improve their effectiveness in their chosen career. At the same time, we are developing a practical application approach to general education, using sociology as the example.

This paper is submitted as an attempt to encourage a sympathetic symbiosis between these two fields, between technical education and general education, and to provide the student with experience on a practical and hopefully realistic level.

We have learned and have begun to really understand that contemporary society in the United States is not monolithic. The anthropologists and the cultural historians have helped us come to this realization. The anthropologist, for his part, possibly, out of a lack of other objects of attention, decreased funding, the ugly American, self-effacement syndrome, and the sheer fact of change, has turned his attention to our society. It is important to note that until recently our culture was described in a manner that if brought back from the "bush" would have been viewed with more than a little skepticism. Rarely was U.S. culture examined with the same rigor or perspective as had (to be done) with more exotic groups. In sociology there was a tendency to report on the deviant, different, and abnormal in contrast to what has been the general/ holistic perspective in the study of other cultures.

In recent years sociology and anthropology have laid down their gauntlets and endeavored to fertilize the seeds of each other's discipline. In this paper we attempt to reap part of the harvest.

It might even be said that it wasn't until sociology began using anthropological methodologies and presented its data with an ethnographic flavor that we all began to see the potential and, one might say, responsibility here at home. While sociology is still a long way from understanding the broader implications of research and teaching in a changing post-technological society where integration of data and information is essential for our collective survival, significant strides have been made.

The cultural historians -- much it would appear, as a result of the shock of the Holocaust, the "bomb," Vietnam, Watergate, and the "disappearance of traditional culture" -- have begun to look for more inclusive paradigms, frameworks, and models. In addition they have begun using anthropological methods and sociological perspectives in their attempt to preserve more of the past. The lack of continuity in the historical process since the end of World War II, the "end of ideology," and the work of the conflict theorists have brought the anthropologist, the cultural historian and the sociologist very close together.

This advancement of knowledge and the interdisciplinary fertilization is a positive sign in and of itself, but even more important, at least for some of us, is the issue of application.

> *SCIENCE BY ITSELF IS KNOWLEDGE, SCIENCE APPLIED IS TECHNOLOGY: SOCIAL SCIENCE BY ITSELF IS KNOWLEDGE, SOCIAL SCIENCE APPLIED IS POLICIES AND PROGRAMS.*

This paper addresses one aspect of the application of social science knowledge available in sociology for the delivery of health services.

Policies and programs based on sociology need to be developed to facilitate the enhancement of life chances and life choices.

Health services education is at a crucial point in development. The increase in the use of high energy-powered technology, automated monitoring equipment, sophisticated diagnostic aids, pre-measured, pre-set medications and other examples of time-saving, labor saving, and life-saving devices and procedures has created new problems with the new skills and new work.

The sub-fields of health services are not the "do what you can" of yesteryear, but rather what alternatives have we not tried. The number of personnel in health services delivery and related areas reflects the burgeoning development of specialization and departmentalization. Without overstating the situation, the delivery of health services is complicated, complex, and multifaceted. Health services educators have done a yeoman's job in teaching and training students so that they will be able to handle the complexity and complicatedness of their own technology, but the interactional components of delivering health services is not being given enough attention. Health services educators have enough to do keeping up with their own fields and do not have the time to cover everything. If we do not want increased "burnout" among health services practitioners, if we do not want increased costs of health services, if we do not want only minimal care (both senses of the word), then we as social science educators need to relate the content and process of the social sciences directly to these career areas in our instruction.

Health services education has in its very name the idea/goal of educating as well as training skilled technicians and professionals to assist people

in maintaining and re-achieving emotional and social homeostasis along with their physical-organic systems equilibrium. Health services personnel in the United States receive the best possible training in their respective fields. The most up to date findings, drugs, methods, and technical equipment is quickly absorbed into both the content and process of their training. When they go out into their chosen careers they are as highly qualified technically as possible. If the total delivery of health services involved only up-to-date technical skills, health services educators could rest on their laurels. The picture, though, is not that clear.

Complaints about health services personnel do not generally appear to be in the area of technical competence, but rather in the areas of interpersonal, intergroup, authority, responsibility, emotional and psychological relationships. (The issue of initiative among technicians is one that health services educators still have to resolve.) We wince when we hear comments like "what he does is good work, but he can't seem to get along with his fellow workers," or "she has no respect for authority," or "she has a lousy bedside manner," or "he takes everything personally," or "she falls apart in a crisis situation."

Health services education has borrowed the term "holistic" from anthropology in an attempt to develop a broader, more realistic approach to meeting patient/client needs, but while significant strides have been made, much remains to be done.

The first and foremost task of health services personnel is to understand people, not just in a superficial way, nor in some general stereotypic categorizations, but really understand their behavior. Note that we say behavior, not attitudes, not values, not beliefs, nor any other psycho-emotional labelings.

A key word in psychology is motivation. Motivation, that which gets one moving, acting, doing, can be explained in a variety of ways. Motivation is probably the most multifaceted concept with which we must deal both in our role as educators and our student's roles in health careers. Motivation is determined by gratification from previous experiences. For the new person in a health career, personal motivation and motivating patients/clients is often a hit and miss affair. The patterns used are often those we learned in childhood in school, but they can be inappropriate and even deleterious in health services delivery. Appeals to authority, logic, right and wrong are not necessarily effective. Nor are screaming, cajoling, or even calm reasoning. What motivates one person does not do so for another.

Directly related are the facts of a patient's background. It should be noted that while socio-economic and socio-cultural factors must be considered as contributing to behavioral patterns, individuals may not have internalized these factors into their behavioral repertoire. Particularly in crisis situations, patients may resist acknowledging (to themselves and to others) any association with their heritage. Health services personnel must be aware of these background factors, but from a social scientific verifiable perspective, not through pseudo-specification. Poor blacks, old Jewish ladies, spoiled white teenagers and middle aged overweight salesmen are not categories for therapeutic intervention strategies.

In order to understand our patients, we must first correctly and objectively perceive and observe their behavior. Health services

personnel are taught to observe their patients in a rather peculiar manner. The approach has been to look at and examine the patient/client in terms of systems. While this technique has certain advantages, it places certain systems as superordinate to others, namely the emotional and social systems. The patient becomes a fixed entity to be worked on and altered or changed, not a living behaving organism. The negativism of "what's wrong, how do we fix it and how do we prevent it from going wrong again" doesn't really allow the patient to participate in his/her treatment.

There is the need to involve the patient more in both his/her diagnosis and treatment. While we commend health services educators for a good beginning in this area, there is much more to be done. There is still a tendency to "minister" to the patient with a set of rituals, both active and verbal, that reflect an accepted mythology that is known only to those expert in the cultic behavior.* It is still reasoned that the patient would find it difficult to understand what is being done to and for him or her. There are even times where it is felt that if procedures were explained it would make it more difficult for them to be effective.*

Beyond the interaction of the health services personnel and the patient/client, there are two general areas that compel our attention in the education of health services personnel. In lay language, they are "learning the ropes" and "getting along." In social scientific terminology, they are organizational behavior and interpersonal relations. There are a cluster of behaviors that must be learned in any organization, be it a hospital, clinic, or industrial or home setting. We do not have the license anymore (if we ever did) to say, "leave me alone and let me do my job." With federal, state, and county governments, boards, and controls, we all deal with organizations.

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*Horace Miner, "Body Ritual among the Nacerima," American Anthropologist, 58 (1956), pp. 504-5.
We should also mention that there are still "things" we do that we don't know whether they are going to work or why they do or don't.

Organizations prescribe certain behaviors, attitudes and interactions.** These relate directly to the goal attainment, tension management, adaptation to the external enviornment, and personnel integration of the individuals within the organization and the organization itself with the other organizations. The problems these tasks present could probably be solved separately by the new practitioner, but they must be handled simultaneously with the individual adapting to his or her new role as a practitioner. This is not the time to have to learn how to deal with red tape, personality quirks, racial prejudice, and how you'll score on your provisional job evaluation.

Usually health services organizations are not for profit. In fact, the majority spend their time and energy trying to cut their deficit.* Capital equipment and "administration" are usually considered fixed costs and are the last things to be sacrificed or even reduced in cost-cutting economy actions. Direct service personnel (or salaries) and the "tools of their trades" are the early victims. Personnel have to be taught to conserve, efficiently utilize, repair, make do with less, and even "squirrel away." They also have to be taught how to offer cost-cutting suggestions in a manner that maximizes their chances of acceptance. Even at times when the resources are adequate, basic rules of efficiency and conservation should be observed. Hospital equipment, whether paper, pencils, bandages, tubing, transistors or furniture are not meant to be taken home. Waste should be avoided. Lights should be turned off and while it is true that there are probably not enough personnel, the attitude that "it's not my job" doesn't help at all.

** Coffey, Robert E., et.al. Behavior in Organizations: A Multi-Dimensional View. Englewood Cliffs, N.J.: Prentice-Hall, 1975.

* Health services organizations often were as guilty of overexpanding as our schools were and the consequences are just as severe.

The new for profit operations create another series of problems which will not be discussed here.

Most health services organizations hire many different types of personnel who come from a variety of classes and cultures. In fact, there is probably no area where the outward appearances of desegregation have existed for as long. If there were racial and cultural integration in our health services organizations, we would not even have to mention this item. The reality of the situation is that a caste system often reinforces the existing job category stratification. There is clearly a color gradation among the occupations and it is the unusual situation where there is even minimal socializing off the job and more than common amenities on the job. These issues must be dealt with in a directed manner in order to insure the well-being of all involved.

We have become acutely (sic) aware of the growing problem of mental health among personnel. The health service practitioner works in a highly charged, tension producing and in many ways insecure environment. A milieu of noxious smells, electronic sounds, radioactive materials, drugs, threats and actual violence, low salaries, fatigue, hostility, law suits, poor organization and vacillating management is neither conducive to personal and professional development and growth, nor to the delivery of effective health services. Long before "burn out," debilitation begins to affect efficiency and the more people complain to each other on the job, the worse the situation appears to become. Problems at work get taken home, home problems get taken to work and the least incident gets blown out of proportion, aggravating and exacerbating any temporary or situational personal, emotional, interpersonal or social problem. Because of specialization and departmentalization, the individual in health services is likely to view himself as only a small cog in a large wheel, unrecognized, unacknowledged, and unappreciated. He or she must learn to self-motivate, self-reinforce, self-evaluate, and self-improve. It is recommended that people in the health services learn to do some things that provide both intellectual and emotional stimulation and satisfaction outside of work. Our students must learn their whole life is not work and their work is not all of

life.

While we are on the subject of work pressures, it is necessary to discuss the problems of mixing work and play. Stereotypes aside, socializing on the job must be kept to a minimum for everyone's sake, the patients, the participants, and all others. The shock of the work world, the pressures, tensions, anxieties, the ambivalences and the closeness with which people must work encourages familiarity, and the old expression about what familiarity breeds may not be too far from the mark, if not for the participants, then for those who might be jealous. Without being prudish, the dating game, the mating game, or the bedding game interferes with the effective delivery of health services. While some people can carry on multiple roles in intersecting relationships, it is best to keep them separate. In fact, there may even be organizational policy to that effect, which brings us to the next bit of learning our students need to have.

Management decision making which may appear to be arbitrary, non-directed, at cross purposes, and even capricious impacts the day to day delivery of health services. Professionals must understand the differences among policies, procedures, and actual performance and how they came about, not just their specificity. Knowledge of the whole organization, how it operates, and the individual's place in it and skills necessary for survival are essential. Learning primary and secondary communication systems, how to procure "things" the proper way and the other way goes a long way toward the effective delivery of services and good mental health. Occasionally something doesn't operate properly and changing "S.O.P.'s" without getting oneself in trouble, without offending people and without disturbing the basic delivery of health services is worthwhile learning.

Related is the area of community health. When one looks at this, one must be clear to differentiate between the problems of health in the community and actual community health issues. Many problems that exist are not a function at all of community related factors, that is, they cannot be significantly ameliorated by a change of policy or program. Even when there is a high incidence of a specific problem, there is not necessarily a community health problem. Even in cases where the demographics, socio-cultural or socio-economic factors indicate an area-wide issue, it may be best dealt with on an individual basis. This does not mean that the community health professional has no role; he or she must educate other professionals and responsible leaders as to the nature of the problem.

The other side of the coin is the tendency to lump "causes" of community health problems into catch-all phrases such as "socio-cultural or socio-economic." This form of apologia often obsufucates the possibility of "attacking" the problem by making the problem appear beyond the control of anyone. It is not always the case that only a major social change will impact on the problem. It may be best from a professional point of view to identify the elements of the problem that exist at the individual, organizational, institutional, and system levels. At the same time it is incumbent upon us to determine to what extent social, economic, cultural, environmental, political and demographic factors are separately responsible for the problems as well as dealing with the nature of the medical/nursing problems.

With a health services career comes multiple interactions with persons other than the patient and other professionals. If the patient/client were the only "outside" person with which we had to work, we would probably be much happier. We live in a mass-mediated culture with a profusity of lay medical knowledge, most of it incorrect or overgeneralized, and most people consider themselves experts. But families and friends are here, concerned, and honestly

interested in the patient's welfare. What they do and do not do is often the stuff of which horror stories and comedy routines are written. Minimally, their presence or telephone calls can interfere with our doing our jobs. We must teach our students how to interact with these people as effectively as they should interact with patients and other health services personnel. We must also learn how to teach families and friends to assist us with direct patient care, rehabilitation, post care education and preventive medicine. We must also give them correct information and make them understand our limitations.*

One of our limitations is our mortality and the mortality of all those with whom we work, yet we are less prepared for dealing with this reality than any other which we deal. The subject of death and dying which has a wide press both in the health services and outside is one of the most difficult areas that our people will be required to handle personally as well as professionally. It is also a good example of what is meant by being unable to deal with something that is too close. It also points to the clear need for humanizing technologies. A sensitivity needs to be learned so that emotionality does not get in the way of delivering effective services. A set of structured experiences with practical applications of philosophy, ethics, logic, argumentation, and all the humanities, not just lectures and units on the philosophy of nursing, bioethics, medical research taught by health services educators, must be designed for all the subfields, no matter how restricted the technician will be on his/her job.

Thus, all that we've said up to this point may be irrelevant to most of our students most of the time. While every organization is different, every department will have different policies and procedures, and every physician

*We must also mention that our relationships with clergy could use improvement.

will permit technicians at different levels to do different things at different times, health services personnel need to know how to be a human being in a human situation working with other human beings. The integration of culturally relevant concepts of group and group process into the learning process of nurses is essential for the effective delivery of health care in a modern, multi-ethnic, multi-racial, mobile society.

It is not the purpose of this paper/work to simply add to the curriculum. We realize that most technical programs are not going to add more social science courses and may very easily reduce the general education requirements under pressure of funding patterns and the technological information explosion. Thus, it was tempting to simply take the terms from the indexes and glossaries of the introductory textbooks that seemed most relevant and list them with definitions. We have learned, though, that material that is not obviously useful is quickly forgotten. Nursing instructors are busy enough with their current responsibilities to try and figure out what they need and how to use it. It seemed more functional to take a few terms and develop learning experiences that could easily be "plugged into" existing courses. These activities/experiences/exercises presented can serve as models for teachers in other technical fields that are currently overwhelmed with changes in their own fields and do not have the leisure to explore the possible contributions of the social sciences to their students' education. The activities should also encourage the social science instructors to get assistance in making their courses more relevant.

In order to provide more than an intellectual exercise, several steps were taken in the construction of this paper.

1. A listing of core concepts in sociology from introductory texts was made.*
2. Validation of concepts from applied areas was conducted.
3. A concept/content analysis of texts used in nursing foundations and nursing process courses for inclusion of sociological concepts was done and a list made.
4. Where major concepts from sociology were not discussed, a list was made.
5. From these lists, exercises that could easily be accomplished were developed.

These exercises (see Appendix) include objectives, suggested readings, the activity, and write-up or discussion topics. The concepts picked were those that instructors and students in nursing perceived as most important.

POWER AND AUTHORITY

Authority is an issue even under ideal conditions. Except for the private office and a few other circumstances, each category of functionary (e.g., nurse, physician, therapist, aide) has its own director/manager/head to which sic the individual stands in a formal subordinate relationship. Individuals in the work situation, though, are responsible to other individuals (e.g., the surgical nurse is responsible to the surgeon). One must also make the distinction between these two forms of institutionalization of power on one hand and the ability to "command respect." In a structured organization within a structured society, the arrangements of relationships is based upon established statuses with relative amounts of power, privilege, and prestige. The "chain of command" which is associated with bureaucracy is necessary within a complex organization. The health care practitioner must be able to operate within the formal structure of the setting; the alternative is chaos. But, efficient and effective care may best be delivered in a different manner. Thus, the nurse must learn both the

*See Caplow, Theodore. Sociology. Englewood Cliffs, N.J.: Prentice-Hall, 1972.

formal and informal processes of the setting and be able to make the distinction between circumventing the authority system because of need and simple disrespect.

VALUES AND PROCESS

One of the issues that is presumed throughout this paper is that the nursing student is in the process of becoming a member of a new society (for him or her), with its particular culture and thus needs to learn how to behave. The student's teachers, clinical supervisors, and peers will provide direct instruction and support, but the processes of acculturation and resocialization are generally learned only once an initiate is a full-fledged member. This form of culture shock is often needlessly traumatic.

One of the purposes of this paper is to provide some mechanisms to reduce the adjustment problems, prevent conflict, and encourage a more positive attitude toward the real work world. Burnout, cynicism, fatalism, and callousness must be avoided. There is also the hope that the nurse who learns additional perspectives will be more objective and realistic in working with patients/clients and personnel from diverse backgrounds. This student should also be able to distinquish between functional and dysfunctional change.

As we reviewed nursing curricula, we found that the integration of process issues and content was given some discussion time, but less clinical association. There is some acknowledgement of cultural issues, but relatively little time is devoted to real life situations. The more theory oriented the program, the less clinical experience is seen in the areas we are addressing.

ETHNICITY

In nursing texts, including several written specifically for ethnic

awareness, there appeared to be a concern for certain issues. Awareness of family, diet, folklore, including folk medicine differences was dominant, but issues of intergroup and interpersonal relationships within the health care setting was given minimal attention. Racial-color issues are discussed, but few solutions are offered except in the area of diagnostics. There is an overriding impression that once cultural phenomena are mentioned, educational responsibility has been properly discharged. In only one supplementary text was there any attempt to indicate to the nursing student that she/he has a role to play. The holistic concept of nursing requires more than this psychological approach to issues of personality, group, organization and culture.

One must be careful to avoid a form of reductionism by attributing cultural causes to complex phenomena. Culture is differentially learned, understood, and internalized by each member of a particular society or sub-group. That an individual may come or appear to come from a specific aggregate does not mean that one can "blame" his/her behavior on culture. All blacks, all chicanos, all Puerto Ricans, all Vietnamese are not alike, nor is their adherence to our perception of their traditions. For example, a portion of Vietnamese are Catholic, so that their behavior may be different than a Vietnamese with a Buddhist tradition. Their views on the role a family should play with, say, impending death would be different. Further, Vietnamese from the urban centers of the south may have a different perception of health care by "foreigners," than Viethnamese from the rural north.

RELIGION

To note on an admission card that a person is of a particular religion does not respond to the complexity of the issue. In what would appear to be extreme cases, as with Orthodox Jews, Jehovah's Witnesses, Christian Scientists, etc., the nurse is assumed to be cognizant of potential problem

areas. But we must also be aware of behavior that may appear to be idiosyncratic, while it is related to the practices and beliefs of a religion. Sorcery, personal spirit communication, impersonal forces, and magic may have significance. So too are jewelry, icons, amulets, even certain colors, flowers, or words.

Religion is a good example of so-called cultural residuals. Cultural residuals may be attitudes or behaviors that have been carried over from past generations and are internalized, often with a high degree of denial, into the individual's repertoire. An individual who constantly uses his hands in communication may have no other sense of his ethnicity, but might display resistance to intravenous procedures if his arms were restrained. Or, an individual from a culture that has a different sense of territoriality/proxemics may become uncooperative if the attending professional is too close physically (especially without explaining the need for closeness), or vice versa. Some cultures are very "touchy" and may misinterpret "professional distance" as lack of concern.

AGED

Even in the area of nursing care of the aged, little is said about cultural issues. "Reversion to traditional coping mechanisms" just doesn't explain the diversity of behavior. A significant segment of the population of this country has never been fully integrated into the dominant culture. The immigration since World War II calls for a higher level of sensitivity and sympathetic action on the part of health care professionals.

LANGUAGE

We have usually assumed that unless we had documentation of mental incapacity, brain damage, or foreign birth, we could communicate effectively and in general understand our patients. But, language competence is not the

same for all segments of any specific population, let alone among individuals who have been reared in different locations. Nor can we assume that we as professionals are always making ourselves understood. Because our effectiveness is based on our ability to communicate effectively, we must work on our ability to do this.

WELLNESS

Finally, it is not safe to assume that our conceptions of wellness and illness are universally shared. It is as variable as concerns over toilet training, weaning, death and dying and cleanliness. Our lack of tolerance for pain, for example is different among different segments of the population. We expect that our patients will tell us (when we ask only) whether they are experiencing pain. Further, we expect them to locate it and describe its nature. Tolerance for pain, non-admission of discomfort, and resistance to treatment must be understood within social, cultural as well as psychophysiological contexts. The symbolism of submission, invasion of privacy, the necessity of maintaining body integrity must be related to conscious and unconscious resistance to treatment and care.

CONCLUSIONS

It has been our purpose to suggest some of the content areas of sociology that relate to nursing as a culturally relative career. Nursing was chosen because as a changing field, it has shown understanding of its role in a modern, complex society. It has demonstrated a willingness to utilize new resources, both human and technological. Nursing has maintained its vitality through adoption of a holistic model. Sociology was chosen because it can make a significant contribution.

Additional concepts need to be explored. Of particular interest is the study of the language of health services, age grading/age sets, interest

groups and voluntary associations, male and female roles, and taboos and mores. It is probably true that in twenty years there will be further demographical social changes. It is also true that mass society may mitigate against many of the inheritances of the previous generations, but there will always be the need for an objective analysis of the social and cultural elements in health care delivery. The problems may change, but the issue will remain.

This paper has had to restrict its scope to a few elementary concepts. More direct observation of the hospital and other health care settings needs to be done. Delivery systems, though, are not the only aspect of health care that should be examined. It also is hoped that this paper will encourage further research in the general area of the ethnography of education and sociology of knowledge.

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APPENDIX

Who's On First

Area of study - Authority/Power

Concept - role behavior/role expectations

Definition: There exists a controversy, not unlike most controversies that cannot probably be resolved as to whether one is one's own man or woman or whether we are basically molded by those around us. The question is not simply for the academically curious, but is important with regard to our understanding of mobs, propaganda, advertising and authority. We are constantly being bombarded by family, friends, and the mass media, not only with information from which we could pick and choose but with persuasion that is aimed at giving us a distorted view of the world and subsequently ourselves. How we react is not necessarily a function of our intelligence or even a sense of our own good.

Readings: Stanley Milgram. Authority
Erving Goffman. Presentation of Self in Everyday Life.
Hans C. Anderson. The Ugly Duckling.

Activity Objectives: The student will be able to discuss the process of socialization as it relates to daily behavior.
The student will be able to describe habitual behavior and disruption of it and consequences.

Activity Instructions:

1. By now you've been in classes for a few weeks. Carefully observe the pattern of seating of those around you (but not in your nursing classes). Generally, most students sit in the same or almost the same seats each time even when not assigned to them. Chart their positions and their interactions with each other and the teacher.
2. Locate the student(s) who appear to wait for specific others to sit down so they can sit next to them or the student who always sits by the door.
3. Locate the students who sit in the front and the back. Chart the seating arrangements.
4. Take a person's seat and observe their behavior. Be oblivious of them, initially, but then smile and encourage them to sit next to you. Note: some people don't react at all, but others go bananas.

Write-up or Discussion Topics:

1. How much of our behavior is habit? Explain habit in terms of socialization.
2. Can deviant behavior mean that someone was raised differently? Explain.
3. What would happen if you took the teacher's place in class? Explain why this would happen.
4. What would happen if you changed seats at the family dinner table? Why?
5. What are the applications for work in a hospital setting?

Liver and Succatash

Area of Study - Culture and Change

Concept - Acculturation/Assimilation

Definition: The concept of the United States as a melting pot is more wishful thinking than reality. While the diversity of the population remains one of its greatest strengths, differences in value systems that persist stand as potential barriers to effective communication. Individuals, even whole segments of population, may assimilate, that is, they may take on the outward appearance of the indigenous population. They may even assume the goals of their adopted land but they do not necessarily internalize the dominant culture's way of achieving these goals. Their affective as well as cognitive styles of coping may be different than that which we might be tempted to assume.

Readings: Clyde Kluckholn. Mirror for Man.
Laura Bohannan. "Shakespeare in the Bush"

Activity Objectives:
The practitioner will develop an awareness of alternative personality complexes. The nurse will be able to probe for meanings of different signs given by the patient/client verbally and non-verbally.

Activity Instructions:
1. Go to a grocery store (avoid supermarkets) in four different neighborhoods (e.g. Italian, Hungarian, Slovak, Mexican, Cuban, Jewish).
2. Make a list of foodstuffs not found in a mass market, supermarket.
3. Observe and record the general behavior and appearance of the shoppers.

Write-up or Discussion Topics:
1. Explain different ways two basic foodstuffs are prepared (e.g. potatoes, rice, tomatoes, beans) by these groups. Describe the traditional reasons for these manners of preparation. Is ritual or "magic" involved?
2. What are the implications for patient education of differing usage of herbs and spices?
3. How do you assist a patient to modify a traditional diet?

S. O. P.

Area of Study - Socialization

Concept - role behavior/role expectations

Definition: There exists a controversy, not unlike most controversies that cannot probably be resolved as to whether one is one's own man or woman or whether we are basically molded by those around us. The question is not simply for the academically curious, but is important with regard to our understanding of mobs, propaganda and advertising. We are constantly being bombarded by family, friends, and the mass media, not only with information from which we could pick and choose but with persausion that is aimed at giving us a distorted view of the world and subsequently ourselves. How we react is not necessarily a function of our intelligence or even a sense of our own good.

Readings: Stanley Milgram. Authority
Erving Goffman. Presentation of Self in Everyday Life.
Hans C. Anderson. The Ugly Duckling.

Activity Objectives: The student will be able to discuss the process of socialization as it relates to daily behavior.
The student will be able to give an example of Cooley's, Looking Glass Self.
The student will be able to describe habitual behavior and disruption of it and consequences.

Activity Instructions:

1. By now you've been in classes for a few weeks. Carefully observe the pattern of seating of those around you (but not in your Sociology class). Generally, most students sit in the same or almost the same seats each time even when not assigned to them. Chart their positions and their interactions with each other and the teacher.
2. Locate the student(s) who appear to wait for specific others to sit down so they can sit next to them or the student who always sits by the door.
3. Take that person's seat and observe their behavior. Be oblivious to them, initially, but then smile and encourage them to sit next to you. Note: some people don't react at all, but others go bananas.

Write-up or Discussion Topics

1. How much of our behavior is habit? Explain habit in terms of socialization.
2. Does deviant behavior become normal when enough people do it? Why?
3. What type of commercials are based upon the principles of socialization?
4. What habits in nursing should be encouraged? What habits should be discouraged? Why?

Area of Study - Culture/Personality

Concepts - Values, Norms and Beliefs

Definitions: Most of the discussion in this paper is behavioral in nature. While it is difficult to teach values, they remain an important element of the cultural frameworks within which we work. The values, norms and beliefs and perceptions of importance of the institutions are essential elements in the effective delivery of health services. The nurse must be aware of her values and at least the possibility of different values of people with whom she interacts, including those of the patient and his/her family. In every thing from genetic counseling to oncology and thanontology, the ability of a nurse to understand and be understood is determined by these values. For example, a patient that has a disease/illness that "can go either way" may view that disease/illness as some form of personal punishment for past compromise on traditional values, whether in behavior or thought only. The nurse must get to the root of this feeling in order to be effective.

Readings: J.D. Salinger. Catcher in the Rye.
Kurt Vonnegut, Jr. Slaughterhouse Five.

Activity Objectives:

1. The student will develop a personal definition of personality.
2. The student will be able to describe the cultural, social, interactional and personal aspects of personality.
3. The student will be able to apply the idea of relativeness of values to real life situations.

Activity Instructions:

1. Mark your personal priorities from the list on the next page, (1) for the most important and (19) for the least important.
2. Write down the priorities of someone you think you know very well (husband, wife, intended, etc.).
3. Duplicate the blank list and ask the person you selected for #2 to list their own priorities.
4. Ask them to list what they think are your priorities.
5. Compare the four lists.

Write-up or Discussion Topics:

1. Define values, norms and beliefs. How do they operate in reality? Give examples of how they affect behavior.
2. Are values absolute or relative? Explain, using your activity.
3. Write a care/teaching plan for a patient that believes that deaths come in threes and has just "lost" two of his/her friends.
4. What values that you hold have changed because of nursing? How and why?
5. What values may change as you spend time in the field? Why?

A COMFORTABLE LIFE
(a prosperous life)

EQUALITY
(brotherhood, equal opportunity for all)

AN EXCITING LIFE
(a stimulating, active life)

FAMILY SECURITY
(taking care of loved ones)

FREEDOM
(independence, free choice)

GOOD HEALTH
(physical, mental)

HAPPINESS
(contentedness)

INNER HARMONY
(freedom from inner conflict)

MATURE LOVE
(sexual and spiritual intimacy)

NATIONAL SECURITY
(protection from attack)

PLEASURE
(an enjoyable, leisurely life)

SALVATION
(saved, eternal life)

SELF-RESPECT
(self-esteem)

A SENSE OF ACCOMPLISHMENT
(lasting contribution)

SOCIAL RECOGNITION
(respect, admiration)

TRUE FRIENDSHIP
(close companionship)

WISDOM
(a mature understanding of life)

A WORLD AT PEACE
(free of war and conflict)

A WORLD OF BEAUTY
(beauty of nature and the arts)

Area of Study - Culture and Change

Concept - Age grade/Age Set

Definition: We continue to talk about a communications gap between people of different ages. In many respects this is a reality, caused by some real changes our society has undergone. Each and every generation sees the changes that it experiences as revolutionary. In many respects they are correct. Because we gave much of socialization (learning how to live in specific groups) and enculturation (learning how to live in general) over to groups other than the family and religion to handle, each new age group to come along learns not only different things but learns to think and feel differently.

Activity Objectives:

Teaching and ministering to different age groups requires not just information about biological changes and sensitivity to alledged psychological changes that people undergo as they age, we also need the skills to communicate and interact effectively.

Activity Instructions:

1. Ask 5 people in each of the following age groups - 18-22, 23-30, 30-45, 45-60, 60+, - to define these terms.

Internist
Psychosomatic
Dropsie
Convalescent
Rehabilitation
Nursing Home
Extended Care Facility
Crisis

2. Are there any significant differences between age groups?
3. Are there any terms that one age group or another could not define?
4. Compare the definitions in an abridged dictionary and the glossary of Tabers Medical Dictionary. Are there significant differences?

Write-up or Discussion Topics:

1. In interacting with patients of different ages what assumptions about different age groups should we and should we not make?
2. How would you overcome a "Communications gap" of a "Generation gap"? Would a nurse of a different age set understand patients differently?

A Rose by any other Name May be an Allergy

Area of Study - Culture, Language

Concepts - Signs/Symbols

Definitions: It is interesting how we relate to certain objective phenomena - sometimes very predictably and sometimes not so predictably. In the social sciences signs or signals and symbols are two terms that can be used to help explain this behavior. The term sign has two overlapping meanings. Directly related to the study of individual behavior, as in psychology, sign stands for a genetically determined response to a given stimulus as in the pain felt when burnt or the eye blink when startled. Sign also refers to that which directly indicates something; a motion, gesture, or mark that appears to have virtual universal meaning.
Symbols, on the other hand, are genetically independent, that is, their meaning has to be agreed upon by a particular social group. Symbols stand for something else by association. The item, idea, or concept is not bound temporally or spatially. A red octagon and a skull and cross bones are two symbols. Confusion arises in that we combine signs and symbols. The red octagon usually says STOP and is at a corner. The skull and cross bones usually is accompanied by other indications of poison (or pirates). We even say stop sign. Yet in an international system of traffic signs, stop is indicated differently.
The dominant form of symbols of any culture is language, but not simply the denotative meaning of the words, but that which goes beyond. Words like cool, hot, square, even black and white conjure up images that are different for different aggregations and collectives of persons. The study of symbolizing has even crossed over into what once was thought to be beyond individual and social control, that is genetically determined responses; signs, in the area of body language and gestures, called kinesics.

Readings: Mario Pei. The Nature of Language.
Arnold Birenbaum and Edward Sagarin, "The Deviant Actor Maintains His Right To Be Present: The Case of the Nondrinker."

Activity Objectives:

1. The student will be able to distinguish between signs and symbols.
2. The student will be able to relate this concept to those of social and symbolic interaction after discussion of the latter.
3. The student will be able to describe differences of meanings of symbols and some of the reasons for these differences,

Activity Instructions:

1. Write down the first associations that come into your mind as you vocalize the words:

One
Two
Three

Over

2. Ask ten people (not in your class) to do the same. Make sure you get some data on these people, such as: age, sex, religion, race.

3. Compare your answers with your classmates.

Write-up or Discussion Topics:

1. Are numbers signs or symbols or both? Support your answer.

2. Are there any characteristics of the respondents that will allow you to categorize their responses? Why is this so?

3. If you asked persons from different countries or vocalized the numbers in different languages, like French or Spanish, would the answers be different? Why?

4. What other common symbols that we use in nursing might be understood differently by someone from a different culture?

"I Don't Know, I Just Live With Him"

Area of Study - Traditions

Concept - Relationship/Affinity

Definitions: Relationship is a fuzzy term. Based on U.S. majority culture, we reckon our reality (to whom we are affiliated, related) and our descent (from whom we inherit biologically and materially) from both the maternal and paternal sides. Our kindred system, while not unique, may in part be based on our residence patterns-urban/neolocal (taking a new home in the city after our marriage.
Affinity has two meanings: to whom we are attracted and appear similar and those who are brought into contact/joined by a marriage as in the case of two sets of in-laws. The latter definition from anthropology may explain some of the problems health practitioners have with "families" of patients/clients. It is to the other half of the definition of affinity we must look for our solution.

Activity Objectives:

1. The student will learn some of the clues and cues for differentiating between "next of kin" and people with whom a patient wishes to interact.
2. The student will understand that different cultural groups have different rules and practices with regard to familial responsibilities.

Activity Instructions:

1. Select five students who are not in this class and ask them the following questions:
    a. If you were stuck on the road, who would you call for help?
    b. Whom would you call to borrow clothes for a party?
    c. If you had to be hospitalized out of town:
        1. Who should be notified?
        2. Who would be the most help to the doctor? with information about you?
        3. Who would you want by your bedside?

Remember to say thank you.

Write-up or Discussion Topics:

1. Who did your respondent name; friends, really closely related relatives, more distant relatives, or others?
2. Could age, sex or ethnic background explain respondents answers? Why?
3. Describe a possible problem in this area in a hospital setting and how it should be handled.

To the Instructor:

Our students need to become more aware of differences that exist among various ethnic groups as to who will actually be the most help in our work with a patient/client.

Students should not be told to abridge rules, but a need for flexibility should be encouraged. We all know that relatives don't always get along with each other and special attention should be paid to patients prior to and after visits from different persons.

Homecare and after care professionals also must be aware that "even though the wife of the patient has a sister who is an LPN", the patient may have strong ethnic prohibitions against being touched by his sister-in-law.

Try the Yellow Pages

Area of Study: Gemeinschaft/Gesellschaft

Concept - Anonymity/Connectedness

Definition: One of the problems of the "melting pot" society is the possibility of the loss of identity. In a health care setting, this possibility becomes a probability with the need for efficiency of operation. Patient information and history taking is often reduced to that which is directly related to the problem at hand. The patient/client often does not have the opportunity to describe peripheral matters that are important for the delivery of holistic care.
Involvement with the community is essential. On-going liasons with specific as well as "umbrella" social agencies may be required. Sometimes the expertise needed is not available in the health care setting and practitioners must have access to outside resources.

Activity Objectives:

1. The student will learn about the availability of different types of services outside of the immediate setting.
2. The student will learn how to reduce the anonymity of patients/clients.

Activity Instructions:

1. Using the yellow pages:
   a. locate an ethnic association.
   b. locate a private social agency.
   c. locate a community health agency.
   d. locate a community mental health facility.
   e. locate a community "umbrella" or major referral agency.
2. Interview each of the above:
   a. for their function and role in the community.
   b. determine their hours of operation.
   c. determine their fee structure. Do they accept third party payment?

Write-up or Discussion Topics:

1. Under what circumstances would you use/need each of these agencies?
2. In a hospital setting which would you contact first?
3. Describe how to "follow up" ater a referral.